Investigation of a complaint against the Belfast Health & Social Care Trust

Report Reference: 202004119

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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Listed Authority: Belfast Health and Social care Health Trust

SUMMARY

I received a complaint about the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant's late father (the patient). The complainant raised concerns about the Trust's decision to conduct a flexible[1] cystoscopy procedure with the patient, and the care and treatment it provided in respect of that procedure. The patient sadly died within two weeks of the procedure. The complainant felt the Trust should have conducted a serious adverse incident review as a result, but that it hadn't done so.

The investigation established it was reasonable and appropriate for the Trust to have conducted the flexible cystoscopy procedure. However, it found the Trust should have provided the patient with more information on the potential risks associated with it in advance. This constituted a failure in care and treatment.

The investigation further established that the Trust's actions regarding medication and the patient's discharge were reasonable and appropriate. Furthermore, it established that whilst the procedure caused an infection that contributed to the patient's final hospitalisation, it did not contribute directly to his death. As a result, the investigation also found it was not necessary for the Trust to conduct a serious adverse incident review following the patient's death.

I therefore partially upheld issue one of the complaint, and did not uphold issue two.

I recommended the Trust provides the complainant with a written apology for the failure identified within one month of the date of the final report. I made two further recommendations for the Trust to address to instigate service improvement and to prevent future reoccurrence of the failing. I asked the Trust to provide this Office with evidence of steps taken within three months of the date of the final report.

[1] A diagnostic procedure which allows a telescopic examination of the inside of the bladder

THE COMPLAINT

1. This complaint was about care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the patient with regard to a Flexible[2] Cystoscopy procedure carried out on 4 December 2020. The complaint is that the procedure was unnecessary due to the patient's age and existing health issues. The complainant is the daughter of the patient.

Background

2. The patient was referred to the Belfast Trust Urology Service with pain, dysuria[3], haematuria[4] and a PSA[5] of 111. The complaint is that the flexible cystoscopy was unnecessary due to the patient's age and existing health issues. The patient was 90 years old, had probable prostate cancer, and a history of COPD, chronic kidney disease and was a Type 2 diabetic. The complainant asserts that her father was not given adequate information to make an informed decision regarding the procedure, as he was told he was attending for a "bladder camera test". The patient was admitted to hospital on 6 December 2020, that is, two days after the procedure. He died there on 13 December 2020 from upper gastrointestinal bleeding. The complainant has concerns that the procedure of 4 December 2020 may have contributed to his death.

Issues of complaint

3. I accepted the following issues of complaint for investigation:

- **Whether the care and treatment provided to the patient with regard to a Flexible Cystoscopy, carried out on 4 December 2020, was reasonable and appropriate?**
- **Whether the care and treatment received by the patient warranted a Significant Adverse Incident review.**

[2] A diagnostic procedure which allows a telescopic examination of the inside of the bladder
[3] Painful or uncomfortable sensation during urination
[4] Blood in the urine
[5] Prostate Specific Antigen level in the blood. PSA is a protein made only in the prostate gland.

INVESTIGATION METHODOLOGY

4. In order to investigate this complaint, the Investigating Officer (IO) obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included the correspondence from the Trust to the complainant generated during the complaints process, the patient's medical records relating to the flexible cystoscopy on 4 December 2020 and a previous flexible cystoscopy carried out in February 2015. The IO also obtained additional hospital clinical records for the period 6 December 2020 to 13 December 2020.

Independent Professional Advice Sought

5. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisor (IPA):

    - A professor in renal cancer and consultant urology surgeon (IPA) with 16 years' experience of managing patients with suspected urological cancer as part of her day-to-day practice.

    I enclose the clinical advice received at Appendix two to this report.

6. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA provided 'advice'. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

7. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

    The general standards are the Ombudsman's Principles[6]:

    - The Principles of Good Administration

[6] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

8. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

   The specific standards and guidance relevant to this complaint are:

   - The General Medical Council's Good Medical Practice, updated April 2019 (the GMC Guidance);
   - The British Association of Urological Surgeons, haematuria consensus guidelines, July 2008;
   - www.nhs.uk/conditions/bladder-cancer/diagnosis;
   - www.nhs.uk/conditions/cystoscopy/how-its-done;
   - https://cks.nice.org.uk/topics/dyspepsia-proven-peptic-ulcer/background-information/risk-factors/;
   - www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/morbidity-and-mortality-meetings/;
   - National Institute of Clinical Excellence (NICE) Prostate cancer: diagnosis and management, guideline NG131;
   - Core Surgical Training Curriculum August 2021;
   - Clark KR, Higgs MJ, Urinary infection following outpatient flexible cystoscopy Nov 1990; and
   - Antibiotic prophylaxis in urological surgery, October 2014.

9. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

10. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. The Trust accepted the report. The complainant also generally accepted the report but reiterated her dismay at the death of her father and of his understanding of the procedure carried out. Whilst not changing my findings and conclusions, I have made certain changes to the report in light of the comments received.

THE INVESTIGATION

Issue 1: Whether the care and treatment provided to the patient with regard to a Flexible Cystoscopy, carried out on 4 December 2020, was reasonable and appropriate?

Detail of Complaint

11. The complaint is that the patient, at age 90 and with existing health issues, the Trust put him through an unnecessary procedure. The assertion is that as the patient's PSA level was 111 and the Trust knew he had prostate cancer, there was no need for him to undergo such an invasive procedure. Thus, the Trust did not give enough consideration to the patient's age and health, as he had a history of COPD, chronic kidney disease, was a Type 2 diabetic and receiving medication for Atrial Fibrillation. The complainant also raised concerns over the level of consent obtained, not ceasing blood thinning medication prior to the procedure, the appropriateness of discharge and that the procedure may have played some part in the patient's death one week later. I consider these issues under the appropriate headlines.

Appropriateness of a flexible cystoscopy

The Trust's response to investigation enquiries

12. In response to investigation queries the Trust stated it "*suspected*" the patient of having prostate cancer, following a referral from the GP to the Trust's Urology Service. The Trust stated that the consultant was aware of the patient's medical history. The flexible cystoscopy revealed a '*grossly enlarged prostate, a trabeculated*[7] *bladder and inflammation at the base of the bladder. A digital rectal examination confirmed an abnormal prostate. The tests, along with the PSA result, confirmed an advanced prostate cancer, for which further investigation and treatment was planned'.*

13. The Trust stated it performed the cystoscopy on 4 December 2020 to investigate the cause of haematuria and to '*primarily exclude dual pathology of bladder cancer as well as prostate cancer'*. The Trust stated the standard

[7] A thickening of the bladder walls making them harder to contract. This leads to a difficulty in emptying the bladder when urinating.

investigation for haematuria is a cystoscopy and that this was appropriate. The Trust further stated that a cystoscopy is not performed to diagnose prostate cancer.

Relevant Independent Professional Advice

14. The IPA advised that a flexible cystoscopy allows for visualisation of the inside of the bladder. It consists of a camera and a light system contained at the end of a very thin flexible tube which can be used under local anaesthetic in an outpatient setting. The IPA advised that it is used '*as a standard investigation for haematuria'* and is also the most '*appropriate means for investigating potential bladder cancer'* when carried out in addition to imaging (CT Urogram[8] or MRI[9]).

15. The IPA advised that Prostate cancer cannot be diagnosed with a flexible cystoscopy and it is '*not part of the prostate diagnostic cancer pathway. Prostate cancer investigations include a digital rectal examination, PSA, MRI, prostate biopsies and bone scan.'*

16. The IPA advised the medications prescribed (Bicalutamide and Decapeptyl) following the procedure are recognised treatments for prostate cancer. In addition, the Trust requested a bone scan to investigate whether there were metastatic deposits in the bone for staging of the prostate cancer. She advised the request for a CT urogram was part of the investigations for haematuria.

17. Overall, the IPA advised that a flexible cystoscopy was a reasonable and clinically appropriate procedure to undertake, despite the patient's age. She advised that *'human rights laws reinforce the ethical obligations on doctors not to discriminate against older patients and to ensure that they receive a good standard of care.*'

[8] A scan with an injected dye to provide a view if the urinary system
[9] Magnetic resonance imaging

Analysis and Findings

18. I note the advice of the IPA that a flexible cystoscopy is not used to diagnose prostate cancer. Steps to investigate this condition include a digital rectal examination, PSA readings, bone scans and MRI, all of which were carried out or being arranged for the patient alongside the flexible cystoscopy. I accept the advice that a flexible cystoscopy along with imaging are standard tests when investigating haematuria, which was one of the reasons the patient's GP had referred him to the Trust. I am satisfied that in this case the Trust conducted the flexible cystoscopy as a means of investigating the patient's bladder. This was to investigate for the cause of blood in his urine, and the potential of cancer in his bladder as well of that in his prostate. I accept that this was the appropriate procedure and that it was clinically justified. I am also satisfied that the patient's age and existing, underlying health conditions should not preclude him having a full examination of any new symptoms, with a view to diagnosis and the potential of beneficial treatment. Additionally, I accept the IPA advice that the proposed treatment and medication for the patient's prostate cancer was clinically appropriate. I therefore do not uphold this element of the complaint.

19. Following receipt of the draft report the complainant questioned the qualification of the clinician who carried out the procedure. I refer to Standard 44 of the GMC Guidance which states that when delegating work, the clinician should ensure the person they delegate to is 'suitably trained and confident'. I accept the IPA advice that it is not necessary for a consultant to oversee the treatment that a core trainee (a doctor undergoing training within a surgical speciality) provides. I do, however, note that a consultant was present at the clinic at the time and was aware of the patient's condition prior to discharge.

Information and consent

Detail of complaint

20. The complaint is that the patient was not provided with sufficient information to make an informed decision. The complainant contended that her father believed the procedure was a scan and was not prepared for an invasive procedure. She demonstrated this by noting that her father cared for her mother full-time and did not put in place any alternative care arrangements for

her mother.

The Trust's response to investigation enquiries

21. The Trust state that the consent form recorded that the procedure was a flexible cystoscopy, the intended benefits were diagnosis, and the serious or frequently occurring risks were bleeding, infection and discomfort as evidenced by a stamp on the form. The form gave the name of the consultant and the name of the doctor, a core trainee who carried out the procedure, and the patient's signature.

Relevant Trust records

22. I note the Trust Form 3 – Consent for Examination, Treatment or Care signed by the patient on 4 December 2020, shows the name of the clinicians involved along with the name of the procedure, the benefits and the serious or frequently occurring risks being covered with a stamp printing out the words Flexible Cystoscopy, diagnosis and Bleeding, infection and discomfort.

Relevant Independent Professional Advice

23. The IPA advised that there was '*very little detail in the consent form, and while it did include the name of the procedure, intended benefits and risks – it could have contained more detail as described in the GMC's professional standards'.*

Analysis and Findings

24. As previously referenced, I accept that a flexible cystoscopy was a clinically appropriate procedure to carry out given the patient's presenting symptoms and following the referral from his GP. The complainant queried the level of information provided to the patient before the procedure in the form of a leaflet provided with the appointment letter and stated that he was not prepared for an invasive procedure.

25. I cannot comment on the patient's own understanding of what he expected when he attended the appointment on 4 December 2020 at the Trust's day procedure unit. Nor can I make judgement as to whether or not the standard

explanatory leaflet (which explained the procedure as a fine tube being passed into the bladder via the water pipe) accompanied the appointment letter. I acknowledge the complainant has expressed her doubts that it was. Nonetheless the patient did receive a letter giving him an appointment and a time and he confirmed his intention to attend. I consider this indicates the patient was aware that he would be attending a clinic and therefore away from his wife for a period of time. I note the IPA advice that procedurally a flexible cystoscopy takes on average 45 minutes to 1 hour and that in this case the timing of 1 hour and 40 minutes, given the patient required transport, to be reasonable. I also note that this was not the first time the patient had this procedure, he had a previous flexible cystoscopy performed in February 2015.

26. I note the consent form signed by the complainant does state that a risk to the patient is '*infection'* and that this had been explained to the patient. The IPA advised that the risk of '*urinary infection after a flexible cystoscopy is about 7.5% in all patients*' but that this risk can be higher in others. I consider this level of risk to be relatively high in what is generally considered to be a safe and routine medical procedure. As such I would expect the clinician obtaining consent should have specifically explained this risk to the patient and evidenced on the form that he did so. I see no evidence of this and therefore, on balance, consider it more likely than not the clinician did not fully explain the risks.

27. Standards 21-24 of the GMC guidance, under the heading 'Discussing benefits and harms' states '*you must give patients clear, accurate and up to date information, based on the best available evidence about the potential benefits and risks of harm of each option, including the option to take no action'*. This includes *'recognised risks of harm that you believe anyone in the patient's position would want to know. You will know these already from your professional knowledge and experience'*. I accept the advice of the IPA that the consent form '*could have contained more detail a described in the GMC's professional standards guidance'*. I consider the Trust's failure to fully explain the possible risks to the patient constitutes a failure in his care and treatment. I am satisfied that this caused him to sustain the injustice of a loss of

opportunity to make a fully informed decision on the procedure subsequently performed. I consider it has also led to an injustice to the complainant of upset and uncertainty regarding the treatment her father received. I therefore uphold this element of the complaint. I comment on the remedy for this shortcoming at the conclusion of this report.

Medication

Detail of complaint

28. The complainant stated the patient was on blood thinners (Rivaroxaban) and was not advised to stop them prior to the procedure. She felt the Trust's response to her internal complaint on this point that bleeding was "*low risk*" was contradictory. In particular when it said, "*There are a small number of patients who will have bleeding, a known complication, so the bleeding is expected to occur in a few unfortunate patients".* The information leaflet also stated '*mild burning or bleeding on passing urine for a short period after the procedure*" in "*almost all patients"*.

The Trust's response to investigation enquiries

29. The Trust accepted it did not ask the patient to stop taking blood thinners. It stated its decision was appropriate because there was a low risk of bleeding as a result of the procedure.

Relevant Independent Professional Advice

30. The IPA advised that a patient would '*not need to stop taking rivaroxaban for a routine diagnostic flexible cystoscopy, because it is considered a minor procedure and bleeding if it occurred would be temporary and limited'* She advised that the risk of stopping blood thinners '*would potentially increase the risk of the patient developing a blood clot which could cause serious complications such as a heart attack, stroke or blockage to the lungs; therefore the benefit of continuing rivaroxaban for a routine diagnostic flexible cystoscopy outweighs the risk of bleeding or stopping the drug'*.

31. The IPA advised that it is important to record that the patient is on blood thinners because if '*the patient is having another procedure at the same time as the flexible cystoscopy which may increase the risk of bleeding, for example having a bladder biopsy or removal of a ureteric stent. If this was the case then the patient would have been advised to stop his medication prior to the procedure.'*

Analysis and Findings

32. I note and accept the advice of the IPA that it is not necessary for a patient to stop taking blood thinners prior to undergoing a flexible cystoscopy. I accept the advice that to do so would increase the overall risk to the patient. The benefit of taking such medication outweighs the very real risk of the patient developing a blood clot leading to potentially more serious conditions. I also note the nursing admission document within the clinical notes, completed on 4 December 2020, records the medications the patient was taking. Within the list of medication, rivaroxaban is clearly highlighted with two asterix on either side. The use of rivaroxaban was also referenced in the discharge letter to the patient's GP. Both documents indicate that the use of this blood thinning medication was known and considered by the clinicians treating the patient. I do not uphold this element of complaint.

Discharge

Detail of complaint

33. The complaint is that the Trust discharged the patient while he was bleeding extensively and in pain, to the extent that his clothes and bedsheets had to be thrown away.

The Trust's response to investigation enquiries

34. The Trust stated the patient did not require admission following the procedure (It stated he did not complain of pain, but acknowledged the scope to his bladder may have passed through his malignant enlarged prostate which may have been more uncomfortable than normal). It stated that while it would have been preferable to monitor the patient for a while, it discharged him as:

a. He was anxious to return home;
b. an ambulance was waiting for him and even a short delay would have meant he missed his slot and would have had to be admitted;
c. this was at a time of hospital restrictions during Covid and admittance would have led to an increased risk of infection; and
d. The procedure was not technically more difficult than normal, while there was some bleeding, there was no clotting and it was expected that this would spontaneously stop.

Relevant Trust records

35. Following the procedure and prior to discharging the patient the Trust completed a 'Procedure Room' checklist at 11.05am. Part of this form had the statement *'patient asked to pass urine'* ticked in the affirmative.

Relevant Independent Professional Advice

36. The IPA advised that after a flexible cystoscopy patients '*can usually go straight home'* and that in this case '*there was no clinical indication to admit the hospital'*. Therefore the IPA advised that the '*discharge home was reasonable and appropriate.'*

Analysis and Findings

37. I accept the IPA's advice that the patient's discharge home was reasonable and appropriate, as there was no clinical indication at that time that he should be admitted to hospital. The patient had passed urine without difficulty after the procedure. I also accept her advice that while there would have been some blood in his urine, as is normal following a flexible cystoscopy, there were no blood clots which would have suggested to the clinicians that (notwithstanding the fact that he was on blood thinners) any bleeding was limited and would stop soon. There is also no evidence that heavy bleeding was noted in the Ambulance or by the ambulance driver taking the patient home. While I understand how distressing and frightening the complainant's description of her father coming home with '*blood from*

head to toe.' I cannot state that given the clinical recordings and the visual indicators available to the clinicians, that discharge at this time was inappropriate. There is also no evidence clinically that the flexible cystoscopy had been carried out procedurally incorrectly or that any organ had been punctured. I also note that December 2020 was a time when extensive Covid 19 restrictions were in place in hospitals. During this time, it reserved admittance for those patients requiring immediate attention. In addition, there was a very real fear of elderly patients acquiring Covid 19 when in-patients.

Subsequent admission to hospital and death

Detail of complaint

38. The patient was admitted to hospital on 6 December 2020 and subsequently died on 13 December 2020. The complainant was concerned that his experience following the flexible cystoscopy may have contributed to his death. Upon arrival at hospital, the patient's notes demonstrate a diagnosis of Urinary Tract Infection/Urosepsis and small bowel obstruction in addition to his other health issues. A CT scan indicated a bleeding ulcer. The patient had acute deterioration and died on 13 December 2020. The complainant queried if infections were in existence prior to the patient's cystoscopy. She also queried the infections and injuries that resulted from the procedure.

The Trust's response to investigation enquiries

39. The Trust stated the patient's urine test indicated no evidence of infection upon arrival to Belfast for the cystoscopy on 4 December 2020. It stated it admitted him to hospital on 6 December 2020, and he subsequently died due to an upper gastrointestinal bleed. It stated a CT scan indicated the bleeding which occurred was likely from a duodenal ulcer, which may have been exacerbated by stress and due to the underlying advanced cancer. It explained the patient would have had little reserve in his body to recover. It acknowledged "*the scope procedure did lead to bleeding and infection which may have increased the stress level and indirectly impacted on the ulcer".*

Relevant Independent Professional Advice

40. On admission to hospital on 6 December 2020 the patient exhibited clinical signs of infection. The IPA advised that '*it is highly likely the infection was a result of the flexible cystoscopy performed on 4 December 2020.*' but that the urine colouration '*would have been a reliable indicator that any bleeding which had occurred had stopped.'*

41. With regard to the patient's duodenal ulcer bleed which ultimately led to his death, the IPA advised that a '*duodenal ulcer is not a recognised risk factor or complication from a flexible cystoscopy procedure'*. She advised that while the associated infection, in combination with the patients age and underlying health issues, may have weakened the patient, '*the acute duodenal ulcer bleed which led to the patient's passing was not directly caused by the flexible cystoscopy.'*

Analysis and Findings

42. I am satisfied that the patient did not show signs of an infection or poor health, over and above his existing health conditions, at the time the Trust conducted the flexible cystoscopy on 4 December 2020. However, I accept the IPA's advice that *'the infection and urinary retention which prompted the admission to hospita*l' were likely due to the preceding flexible cystoscopy. As referenced previously these are known complications and risks of this procedure with approximately 7.5% of all patients acquiring infections. Infection was not the only reason for the patient's admittance to hospital. A CT scan indicated internal bleeding from a duodenal ulcer was also present. On foot of the IPA's advice, I am satisfied it was this condition which ultimately led to the patient's death on 13 December 2020.

43. The complainant had concerns that the procedure of 4 December 2020 may have contributed to the patient's death. Having considered this matter carefully, overall, I accept the advice of the IPA that the acute duodenal ulcer bleed which led to the patient's death was not directly caused by the flexible cystoscopy. I accept the advice that a duodenal ulcer bleed is not a recognised risk factor or complication from a flexible cystoscopy. While I

consider that an infection acquired from the flexible cystoscopy may have contributed somewhat to a degree of stress on the patient's body, I find that I cannot attribute a direct cause and effect from this to his duodenal bleed and subsequent death. His age and underlying health issues, in particular the cancer, which appears to have been quite extensive, would also have been major factors in any depletion in his reserves of strength and reduced his chances of surviving the duodenal bleed. I therefore do not uphold this element of the complaint.

Summary

44. On foot of the above findings, I partially uphold issue one of the complaint.

Issue 2: Whether the care and treatment received by the patient warranted a Significant Adverse Incident review.

Detail of Complaint

45. The complainant is of the view that a Severe Adverse Incident review should have followed from the patient's experience and subsequent death.

Evidence Considered

Trust's response to investigation enquiries

46. The Trust stated that this case was discussed at the monthly Urology and Mortality meeting. It stated the patient suffered a known complication from the procedure, there were no concerns raised over the medical management. Furthermore, the cystoscopy was not directly related to the cause of death. Therefore, no further investigation was considered necessary.

Relevant Independent Professional Advice

47. The IPA advised that, in the circumstances of this complaint, and having considered the guidance on the criteria for incidents to be classified as Serious Adverse Incidents,' *it was reasonable and appropriate not to instigate a serious adverse incident review.'*

Analysis and Findings

48. Following the patient's death, the Trust carried out a review of his care at its monthly Urology and Mortality meeting. The purpose of such meetings is to provide a retrospective analysis of the clinical management of cases where death or admittance to hospital has followed a procedure such as a flexible cystoscopy. Its intent is to identify gaps in care, aiming for future practice improvement. Having viewed the notes of that meeting, I note that its findings are broadly in line of the advice of the IPA, whose advice I accept. I am satisfied that while the patient likely suffered a urinary tract infection and urinary retention following the flexible cystoscopy, '*this was not directly related to the duodenal ulcer bleed'* which ultimately led to his death. Given my investigation reached the same conclusion as the Trust's review, I accept the IPA' advice that *'it was reasonable and appropriate not to instigate a serious adverse incident review'*. I therefore do not uphold this issue of complaint.

CONCLUSION

49. I received a complaint about the care and treatment the Trust provided to the patient with regard to a Flexible Cystoscopy procedure carried out on 4 December 2020. Overall, and having considered the independent professional advice received I consider that a flexible cystoscopy was an appropriate and clinically justified procedure to undertake, that it was appropriate not to cease blood thinning medication. I found that the discharge from hospital following it was appropriate and that the duodenal bleed which led to the patient's death was not directly related to the flexible cystoscopy.

50. However, I did identify that the Trust, in obtaining consent to perform the flexible cystoscopy should have specifically explained the level of risk to the patient and evidenced this. I consider this failing to have caused the complainant to have sustained the injustice of frustration and uncertainty over the treatment the patient received. It also caused the patient a loss of opportunity to make an informed decision about his treatment.

51. I offer through this report my condolences to the complainant and the wider family circle for the loss of their much loved father. The anguish and shock of his death is evident in the correspondence I have examined during the course of my investigation of this complaint. The sense of loss has been heightened by the inability to be with him at the time of his death due to Covid restrictions. I hope that this report has gone some way to address the complainant's concerns.

Recommendations

52. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failure identified at paragraph 26 (within **one month** of the date of this report).

53. I further recommend for service improvement and to prevent future recurrence that the Trust discuss the findings of this report with the clinicians involved in the patient's care.

54. The Trust should provide training to relevant staff to include explaining to patients, when obtaining consent, the level of risk involved in procedures to be undertaken, and that this be evidenced.

55. I recommend the Trust implements an action plan to incorporate these recommendations and should provide me with an update **within 3 months** of the date of my final report. The Trust should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies).

Margaret Kelly
Ombudsman

November 2024

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being Customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.